CLEARSIGHT™ LASER CENTER

FRANKLIN W. LUSBY, M.D.

Current Eye Doctor:	Today's Date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Cell/Work Phone#:	Home Phone#:	Email:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	City	State & ZIP Code:

Occupation:	Employer	Employer phone#:	ZIP Code:

Whom can we thank for referring you to our office?	Did they have surgery with Dr. Lusby?	If yes, how are they related to you?

Name of Eye Doctor:_____	❑ Referred by Internet	❑ Referred by Family	❑ Referred by Friend/Co Worker

Other family members or friends seen here:

INSURANCE INFORMATION

Person responsible for payment:	Birth date: / /	Address (if different):	Home phone #: ( )

Occupation:	Employer:	Employer address:	Employer phone #: ( )

Please indicate primary insurance	❑ VSP	❑ MES	❑ Medicare	❑ Other	❑ None

If other, name of insurance:

Subscriber's name:	Subscriber's S.S. #:	Birth date: / /	Group #:	Policy #:	

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Dependant	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #: ( )	Work/Cell phone #: ( )

I hereby authorize ClearSight Management Services, Inc. and Franklin W. Lusby, M.D. to furnish information to my insurance carriers concerning my illness and treatments. I hereby assign to ClearSight Management Services, Inc. and Franklin W. Lusby, M.D. all payments for medical services rendered to me or my dependants. I understand that I am responsible for any amount not covered by the insurance carrier. I understand that drops may be put into my eyes that may temporarily blur my vision for up to 24 hours and have made appropriate arrangements for my transportation and other activities.

_____ _____

Patient/Guardian signature *Date*